ALCALA COUNTRY PET RESORT
PET HEALTH QUESTIONNAIRE

Pet Owner's Name: _____ Telephone Number: _____

Pet's Name:_____Breed:_____

Age:_____

Sex: (Please Circle) Male / Neutered Female / Spayed

Primary Veterinary Care Provider:_____ _____ _____Vet Phone:_____

Vaccinations are usually administered at: Primary Clinic / shot clinic (Vet Co, County Shelter, etc.)

If given at shot clinic, where?_____Phone: _____

Does your pet have any CHRONIC, RECURRING, or LONG-TERM health issues? NO / YES

If YES, please explain:_____

Is your pet presently on medication or receiving other treatment for this issue? NO / YES

If YES, please explain under MEDICATION INFO

Is your pet presently on medication or receiving treatment for any SHORT-TERM health issues? NO / YES *If YES, please explain under MEDICATION INFO*

MEDICATION INFORMATION

Name of Medication:_____Dosage:_____

Frequency:_____

Reason for Medication:_____

Name of Medication:_____Dosage:_____

Frequency:_____

Reason for Medication:_____

Name of Medication:_____Dosage:_____

Frequency:_____

Reason for Medication:_____

Does your pet have any known allergies? NO / YES
If YES, please
list:_____

Does your pet have any dietary restrictions or food sensitivities? NO / YES
If YES, please
explain:_____

Has your pet undergone surgery for any reason OTHER THAN spay/neuter or routine dental work? NO / YES If YES, please explain:

_____
_____
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_____
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_____
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Owner's Signature_____
Date_____